

**NEPHO Health Plan Contract Participation**

Dear Provider,

Members of the Northeast PHO participate in the following health plans:

➢ **Allways Health Partners Commercial**

➢ **Blue Cross Blue Shield of Massachusetts Commercial**

➢ **Cigna**

➢ **Harvard Pilgrim Health Care**

➢ **Fallon**

➢ **Tufts Commercial**

➢ **Tufts Health Public Plans**

➢ **Unicare**

\*Please reference the NEPHO Health Plan Participation by Payor for a breakdown of products per health plan.

As a member of the Northeast PHO, you have the option as an individual physician (or as part of your practice, depending on practice requirements) to participate in the below list of health plans.

**Please check which of the optional health plans below you would like to participate in (if you do not select an option, you will be deemed as participating):**

**Yes No**

**\_\_\_ \_\_\_ Boston Medical Care HealthNet Plan MassHealth**

**\_\_\_ \_\_\_ Boston Medical HealthNet Plan Center QHP**

**\_\_\_ \_\_\_ Commonwealth Care Alliance SCO**

**\_\_\_ \_\_\_ Commonwealth Care Alliance One Care**

**\_\_\_ \_\_\_ Tufts Medicare Preferred (PCPs – please consult with the practice to confirm whether or not they have entered into a TMP exclusive contract and if you should opt into this specific product.)**

**\_\_\_ \_\_\_ Medicare Accountable Care Organization (Applicable to New Tax ID applicants ONLY)**

Northeast PHO physician members are required to enroll as a billing provider in any one of the following MassHealth plans.

Please confirm which product(s) you will be enrolled in through your practice:

* MassHealth Accountable Care Partnership Plan (Model A ACO)
* MassHealth Managed Care Organization (Tufts Health Public Plans, **Boston Medical Care HealthNet Plan)**
* MassHealth Primary Care Clinician Plan
* Mass Health Network

If you are unsure of any product participation, please be sure to ask the office manager at the practice for guidance and/or if there are specific expectations at the practice level.

Please confirm Electronic Funds Transfer (EFT) option has been or will be set up with each health plan for reimbursement purposes.

 **Yes No**

 **\_\_\_ \_\_\_**

Thank you,

NEPHO Enrollment Team

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_